MHS

IHCP 2019 Annual Seminar

Maximizing Your Quality Performance



















Agenda

Part one:

- Pay for Performance (P4P) Measures
- HEDIS® Measures and Codes

Part two:

- Provider Analytics Tool
- My Health Direct
- IMPACT
- Interpreta

W Questions and Answers

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).



2019 P4P Measures

Measure	Measure Name	HHW	HCC	HIP
AAP	Adult Preventive Care		Х	х
ADD	Care for Children Prescribed ADHD Medication	Х		
AMB	Ambulatory Care	Х	х	Х
AMM	Antidepressant Medication Mgmt		х	Х
AWC	Adolescent Well-Care Visits	Х	х	
BCS	Breast Cancer Screening			Х
ccs	Cervical Cancer Screening			х
CDC	Comprehensive Diabetes Care		х	Х
CHL	Chlamydia Screening in Women			Х
CIS (Combo 10)	Childhood Immunization Status	Х	х	
LSC	Lead Screening in Children	Х		
ММА	Medication Mgmt for People with Asthma	Х	х	Х
PCE	Pharmacotherapy Mgmt of COPD Exacerbation		х	
PPC	Prenatal & Postpartum Care	Х		Х
W15	Well Child Visits in the First 15 Mos. Of Life	Х	х	
W34	Well Child Visits	Х	х	

- Pay for Performance (P4P) fund is written into Primary Medical Provider contracts
- Measures differ for each product line
- Measures align with HEDIS® and NCQA
- Annual Pay-Out



P4P ADMINISTRATIVE MEASURES

A Provider is determined to be in "Good Standing" if they comply and complete the following:

- 1. Host, or participate in, a Preventive Health Outreach program or activity,
- 2. Do not have a closed Provider Panel, and are able to accept new members,
- 3. Attendance in one MHS training/orientation session during the calendar year.

OR

1. Enrolls in My Health Direct before the end of the 1st quarter of the new calendar year and remains enrolled through the end of the calendar year.



HEDIS MEASURES AND CODING



Adults' Access to Preventive/Ambulatory Health Services (AAP)

HHW HCC

Applicable members: 20 years and older as of December 31 of the measurement year, calculated separately by line of business.

W Requirements:

- One or more ambulatory or preventive care visits during the measurement year.
- Members must be continuously enrolled for the measurement year with no more than one 45-day gap in enrollment.
- ICD-10 and CPT codes found on page 6 of the MHS HEDIS Quick Reference Guide



Care for Children Prescribed ADHD Medication (ADD)

HHW

Initiation Phase – members with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-days after IPSD.

Continuation Phase – members with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had <u>at least two</u> follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Applicable members: Members who turn 6 years as of March 1 of the year prior to the measurement year to 12 years as of February 28 of the measurement year.

Index Prescription Start Date (IPSD) - The earliest prescription dispensing date for an ADHD medication where the date is in the Intake Period and there is a Negative Medication History.

*Members must be continuously enrolled 120 days (4 months) prior to the IPSD through 30 days after the IPSD with no gap in enrollment.



Ambulatory Care (AMB) ER Utilization

HHW HCC HIP

Applicable members: all members

W Requirement:

- Calculates # Visits/1,000 Member Months.
- Each visit to an ED that does not result in an inpatient encounter counts once.
- Multiple ED visits on the same date of service are counted as one visit.
- ICD-10 and CPT Codes available on page 6 of the MHS HEDIS Quick Reference Guide



Antidepressant Medication Management (AMM)



Acute Phase:

Applicable members: 18 years and older as of <u>April 30</u> of the measurement year.

W Requirement:

- Members remained on an antidepressant medication for at least 84 days (12 weeks).
- Member must be continuously enrolled May 1 of the year prior to the measurement year through April 30 of the measurement year with MHS with no more than a 45 day gap in enrollment.





Adolescent Well-Care Visits (AWC)

- **Applicable members:** Members who turn 12-21 years of age during the measurement year.
- Requirement: At least one comprehensive well-care visit during the measurement year. Medical record documentation must include health history, physical exam, mental developmental history, physical developmental history, and anticipatory guidance/health education.
 - Well-care visit with Primary Medical Provider (PMP) or OB/GYN
 - Member must be continuously enrolled for 12 months with MHS with no more than a 45 day gap in enrollment.
 - ICD-10 and CPT Codes may be found on page 5 of the MHS HEDIS Quick Reference Guide



Breast Cancer Screening (BCS)

HIP

- Applicable members: Women <u>50-74</u> years of age as of December 31st of the measurement year.
- **Requirement:** Women who have had at least one mammogram any time on or between October 1 two years prior to the measurement year and December 31st of the measurement year.
- ICD—10 and CPT Codes may be found on page 11 of the MHS HEDIS Quick Reference Guide.
- * Women who have had a bilateral mastectomy or two unilateral mastectomies can be excluded from this measure. Medical records will be required in order to exclude the member.



Cervical Cancer Screening (CCS)

HIP

- **Applicable members:** Women 21-64 years of age as of December 31st of the measurement year.
- Requirement: Women 24-64 receive 1 Pap test during the measurement year or within 3 years prior OR women 30-64 receive cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years (must occur within 4 days of each other).
- Women who have had either a complete, total or radical hysterectomy (vaginal or abdominal) with evidence that the cervix has been removed can be excluded from the measure based on medical record documentation
- ICD-10 and CPT Codes may be found on page 14 of the MHS HEDIS Quick Reference Guide.

HIP HCC

Comprehensive Diabetes Care

Diabetes Care – Eye Exam

Applicable members: Members ages 18-75 as of December 31st of the measurement year with diabetes (types 1 & 2).

W Requirements:

- Members identified with diabetes (types 1 & 2) who had a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) completed every year OR a negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior.
- Member must be continuously enrolled with MHS for 24 months with no more than a 45 day gap in enrollment.

Diabetes Care –Nephropathy

Applicable members: Members ages 18-75 as of December 31st of the measurement year with diabetes (types 1 & 2).

w Requirements:

- Members identified with diabetes (types 1 & 2) who had a nephropathy screening performed at least once per year.
- A member who is on ACE/ARBs or has nephropathy is compliant for this measure.
- Member must be continuously enrolled with MHS for 24 months with no more than a 45 day gap in enrollment.

^{*} ICD-10 and CPT Codes for CDC-Eye and CDC-Nephropathy may be found on pages 23 & 24 of the MHS HEDIS Quick Reference Guide.





Chlamydia Screening in Women

Applicable Members: Women 16-24 years of age as of December 31st during the measurement year.

W Requirement:

- Women who were identified as sexually active and had at least 1 test for Chlamydia during the measurement year.
- Sexually active women are identified through evidence of a pregnancy test or prescription for a contraceptive.
- Members cannot be excluded for receiving prescription contraceptives for off label use.
- CPT Codes may be found on page 21 of the MHS HEDIS Quick Reference Guide.



Child & Immunization Status (CIS) COMBO 10



- Applicable age group: Children who turn two years of age in the measurement year.
- Requirements: 4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, 1 VZV, 4 PCV, 1 Hep A, 2 or 3 RV (depending on dose schedule), 2 Flu
 - Vaccinations given prior to 42 days after birth or following the members 2nd birthday will not be counted.
 - Members must be continuously enrolled with the health plan for 12 months prior to their 2nd birthday with no more than a 45 day gap in enrollment.
 - ICD-10 Codes available in the MHS HEDIS Quick Reference Guide



Lead Screening in Children (LSC)

HHW

- Applicable age group: Children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning before their second birthday
- CPT: 83655 from page 43 of the MHS HEDIS Quick Reference Guide
- * Children age out every day. Proactive review of open care gaps list is beneficial.



Medication Management for People With Asthma (MMA)

HHW HIP HCC

Applicable members: Members 5-64 years of age as of December 31st of the measurement year.

W Requirements:

- Members identified with persistent asthma who were dispensed appropriate medications and remained on an asthma controller medication for at least 75% of their treatment period.
 Member must be continuously
- Member must be continuously enrolled with MHS for 24 months with no more than a 45 day gap in enrollment.

Appropriate Medications:

- Antiasthmatic combinations
- Antibody inhibitor
- Inhaled steroid combinations
- Inhaled corticosteroids
- Leukotriene modifiers
- Mast cell stabilizers
- Methylxanthines



HCC

Pharmacotherapy Management of COPD Exacerbation (PCE)

- Applicable members: Members 40 years of age & older with COPD exacerbations who had an acute inpatient discharge or ED visit on or between January 1- November 30 of the measurement year and who were dispensed appropriate medications.
 - Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event.



Prenatal & Postpartum Care (PPC)

HHW HIP

Timeliness of Prenatal Care:

- Applicable members: Women who delivered between November 6 of the year prior to the measure year and November 5 of the measure year.
- **Requirement:** Prenatal visit must occur within the first trimester or within 42 days of enrollment.

Postpartum Care:

- Applicable members: Women who delivered between November 6 of the year prior to the measure year and November 5 of the measure year.
- Requirement: At least 1 postpartum visit on or between 21 and 56 days after delivery.

^{*} ICD-10 and CPT codes may be found on pages 54 -55 in the MHS HEDIS Quick Reference Guide.



Well-Child Visits 0-15 Months (W15) HCC

- Applicable members: Children who turn 15 months old during the measurement year.
- Requirement: Six or more well-child visits <u>before</u> 15 months of age.
 - Medical record documentation must include health history, physical exam, mental developmental history, physical developmental history, and anticipatory guidance/health education.
 - Member must have been continuously enrolled with MHS from 31 days to 15 months of life with no more than a 45 day gap in enrollment.
 - ICD-10 and CPT Codes may be found on page 66 of the MHS HEDIS Quick Reference Guide.



Well-Child Visits 3-6 Years (W34)

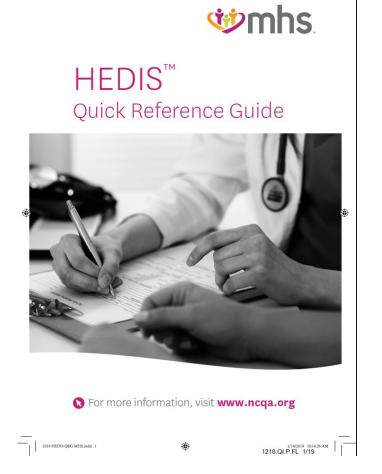
HHW HCC

- **Applicable members:** Members who turn 3-6 years of age during the measurement year.
- **Requirement:** At least one well-child visit during the measurement year.
 - Medical record documentation must include health history, physical exam, mental developmental history, physical developmental history, and anticipatory guidance/health education.
 - Member must be continuously enrolled with MHS for 12 months with no more than a 45 day gap in enrollment.
 - ICD-10 and CPT Codes may be found on page 66 of the MHS HEDIS Quick Reference Guide.



Measure Requirements and Coding

- Find additional information on the measurement requirements and some tips for coding on our website located under HEDIS.
- The HEDIS Quick
 Reference Guide (shown
 here) is available from your
 Provider Partnership
 Associate.





Improving Your P4P Payout



Tools for Achieving a Better P4P Payout

- Secure Provider Portal
- Provider Analytics
- **WIMPACT**
- **WInterpreta**
- **My Health Direct**





Home Find a Provider Portal Login Events Careers Contact Us

Contrast





a a a language -

Select Your Plan Below Which plan do I have?

FOR MEMBERS

FOR PROVIDERS

GET INSURED

Allwell From MHS

Ambetter From MHS

Healthy Indiana Plan

Hoosier Care Connect

Hoosier Healthwise





Find a Provider

Finding a doctor is quick and easy. Search for Primary Medical Providers, hospitals, pharmacies and more.



Opioid Resource Center

Opioid use disorder is a disease. Recovery is possible find support and resources here.



Complete Your HNS

Take the Health Needs Screening (HNS) and start earning CentAccount rewards today!





Home Find a Provider Portal Login Events Careers Contact Us

Contrast



a a a language -

FOR MEMBERS

FOR PROVIDERS

GET INSURED

FOR PROVIDERS

Login

Enrollment and Updates	
Prior Authorization	•
Dental Providers	
Pharmacy	0
Opioid Resources	
Behavioral Health	•
Provider Resources	•
QI Program	•
Provider News	
Email Sign Up	

Portal Login

Create your own online account today!

MHS offers you many convenient and secure tools to assist you. To enter our secure portal, click on the login/register button. A new window will open. You can login or register for a new account.

Creating an account is free and easy.

By creating a MHS account, you can:

- Verify member eligibility
- Submit and check claims
- Submit and confirm authorizations
- View detailed patient list

PORTAL TRAINING GUIDES •



Secure Provider Portal

Login/Register

Provider Email Sign Up

Sign Up

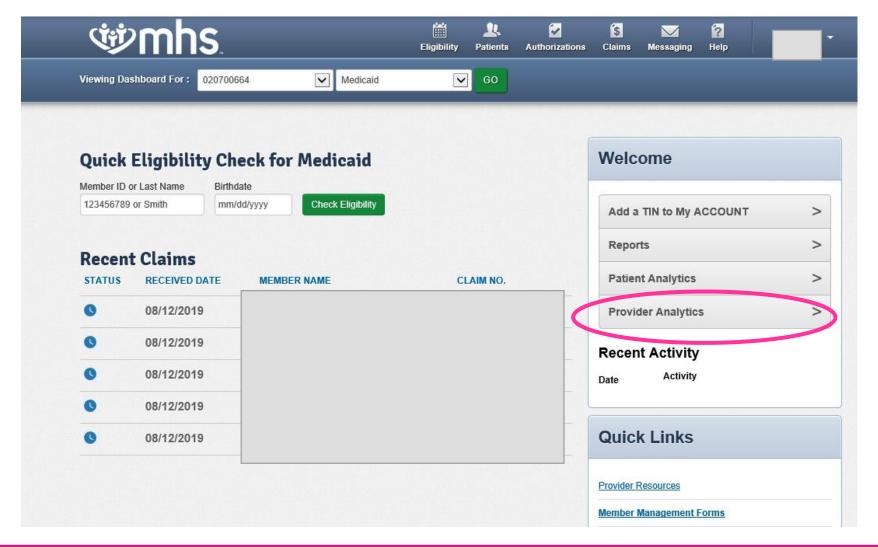
Please note that Clear Claim Connection does not provide an all inclusive listing of claim edits. MHS does utilize additional prepayment review edits in keeping with NCCI procedures and guidelines.

Registration Help

If you are having trouble with your registration, you may need to submit a non-par set-up form. Visit our Become a Provider page to get started. For further assistance, you can call Provider Services at 1-877-647-4848 or see our Account Registration Guide (PDF).

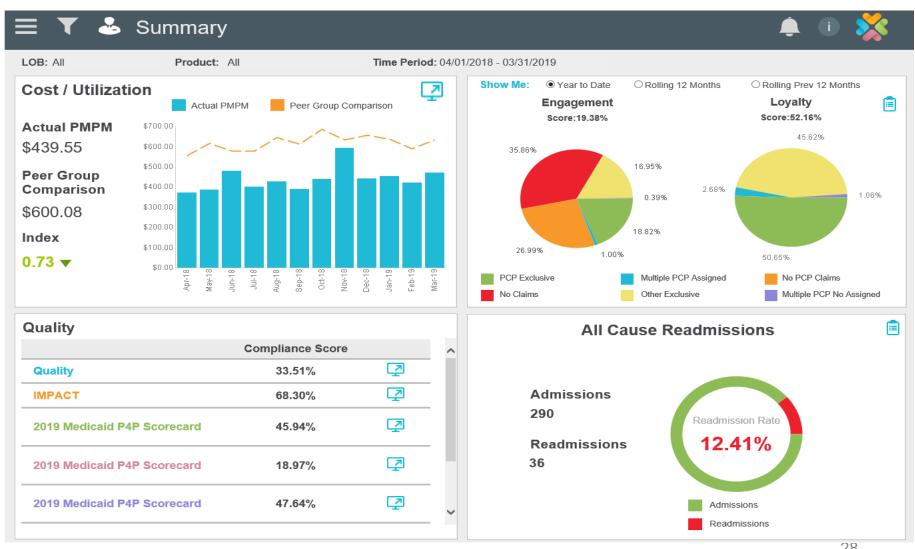


MHS Secure Portal





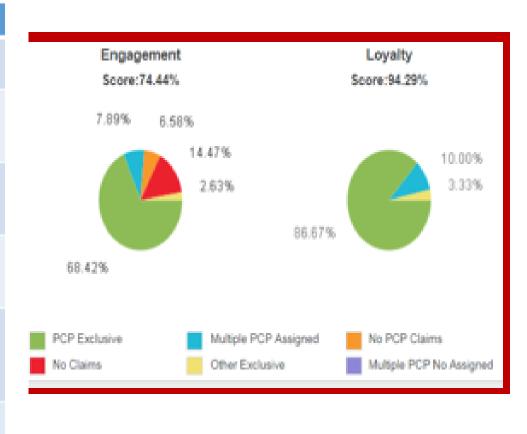
Provider Analytics Landing Page





Provider Engagement and Loyalty

Patient Segment	Segment Traits
PCP Exclusive	These patients have been assigned to you and have been seen by you or one of your partners
Multiple PCP Assigned	These patients are assigned to you, but have been seen by your practice AND other PCP groups
No PCP Claims	These are patients who seek all of their care from specialists, ER, and Urgent Care.
Other Exclusive	These patients are assigned to you, but have been seeing another PCP group exclusively
No Claims	These patients are assigned to you but have no claim data to indicate they have received any medical care from a PCP, emergency department or urgent care center
Multiple PCP No Assigned	These patients are assigned to you, but have only been seen other PCP groups.



^{*}In order to improve quality and cost, it's important to engage members who are not actively being managed; therefore, provider engagement provides the most inclusive view of member activity

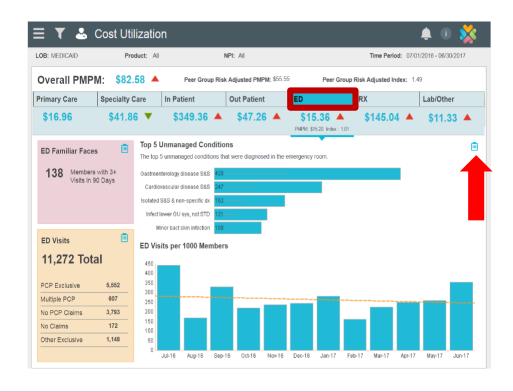


Cost & Utilization: Emergency Department

Shows Per Member Per Month (PMPM) for Emergency Department (ED) visits compared to peers' risk-adjusted PMPM

Properties Four sections:

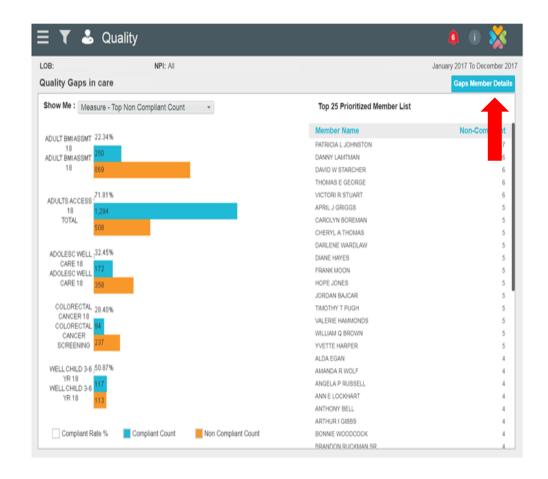
- Bar graph shows top five unmanaged conditions
- Bottom of the page shows average ED visits for provider's patients compared to plan
- Box on top left side shows number of patients with 3+ visits in the last 90 days.
- Box on bottom left side shows number of total ED visits by engagement category.
- Click on the charts for patient-level detail





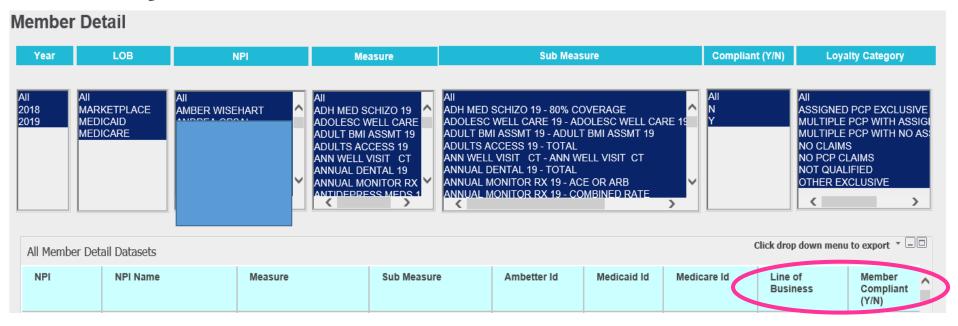
Quality HEDIS View: Gaps in Care

- Left defaults to top five measures by non-compliant count
- Drop-down arrow changes view to see:
 - Measures Non-compliant count, compliant count, compliant rate % or all
 - NPI Non-compliant count, compliant count, compliant rate % or all
- Right side displays top 25 members with the most open care gaps





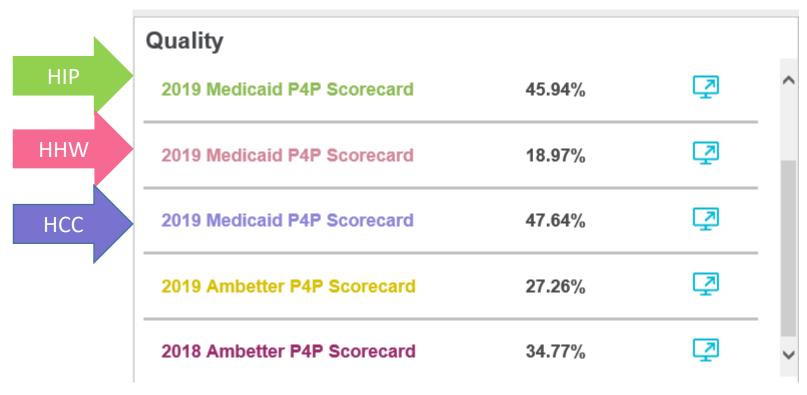
Quality HEDIS View: Member Detail



- Selections can be made to narrow search to a specific year, Line of Business, NPI name, HEDIS measure, Compliant status, or Loyalty Category.
- Providers can customize lists by grouping HEDIS measures into "well-child", "women's health", or just the individual measure.
- Practice resources can be aligned once workload is identified creating efficiencies.
- ❖ Data exports to Excel or PDF available.



Monthly Scorecards



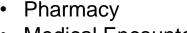


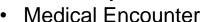
Claims data

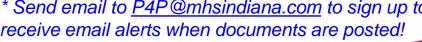


- CHIRP
 - Immunizations
 - Lab results

* Send email to <u>P4P@mhsindiana.com</u> to sign up to receive email alerts when documents are posted!







Medical record

documentation



Quality HEDIS View: Scorecards

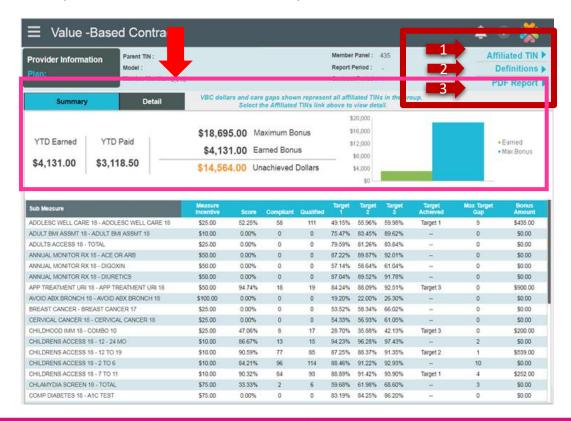
For providers in P4P arrangement

Shows measure incentive, amount earned, and unachieved

dollars

In right hand corner:

- All TINs associated with P4P program
- List of definitions and meanings
- Scorecard summarizing provider's performance in Quality



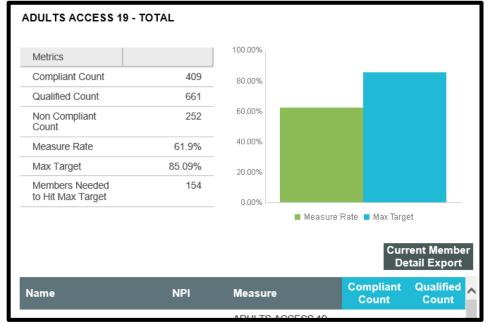


MHS Scorecard Detail



* Example of an actual scorecard.







Annual P4P Payout

P4P Payout calculations are based on final HEDIS Administrative rates and paid at group level.

Pactors include:

- Panel Size—150 minimum
- Required number of members qualified per measure
- Funds from measures without enough members get rolled into other qualifying measures

^{*} Send email to <u>P4P@mhsindiana.com</u> to sign up to receive email alerts when documents are posted!



IMPACT:

Incentive Model for Provider Assessed Condition Tracking

- Rewards providers for consistent high performance in assessing members for preexisting or suspected chronic conditions.
- TINs are eligible to participate if they are assigned at least 100 members.
 - Only members with at least 1 suspected or coded chronic condition are taken into account
 - This program does not require providers or members to apply for eligibility or opt-in
 - All PMPs under the TIN are eligible if the TIN is eligible

- In order to qualify for incentive payment:
 - Participating providers must log into Provider analytics at least once during the performance period
 - Providers must be contracted in our network and have assigned Medicaid membership at the time of the payout reconciliation (which will be made within 180 days of fiscal year end.)



IMPACT Advantages for Members & Providers

Members with chronic conditions will receive regular & proactive assessments; fewer chronic conditions will go undiagnosed or untreated.

Providers will receive incentive payment by continuously improving or maintaining performance in assessing members for conditions.

^{*}Program does not require providers or members to apply for eligibility or opt-in.



IMPACT: PROVIDER PERFORMANCE

W Condition Assessment Rate

- How providers are measured
- Percentage of member-condition combos assessed each year
- Numerator = number of membercondition combos that are assessed
- Denominator = total membercondition combos assigned to provider

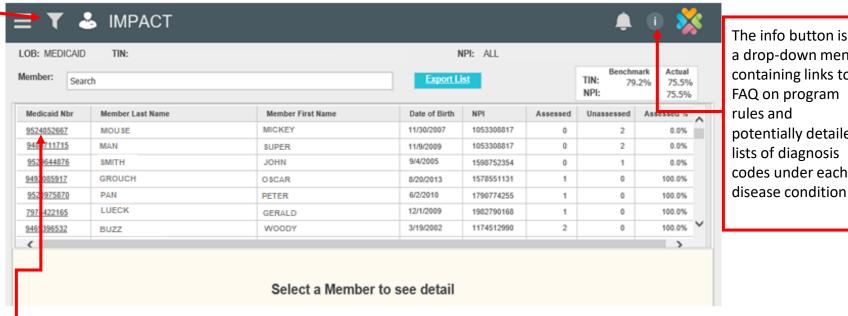
Baseline Performance Rate

- Defined as provider's highest assessment rate from prior years.
- Performance threshold capped at 90-95% (varies by state) to reward providers for maintaining consistent high performance

- Providers are rewarded at the tax identification number (TIN) level for each incremental assessment they complete above the baseline performance
- Incentive amount per incremental assessment = Magnitude of Providers Improvement [minus] Provider's Baseline Performance



IMPACT Navigation of provider analytics dashboard



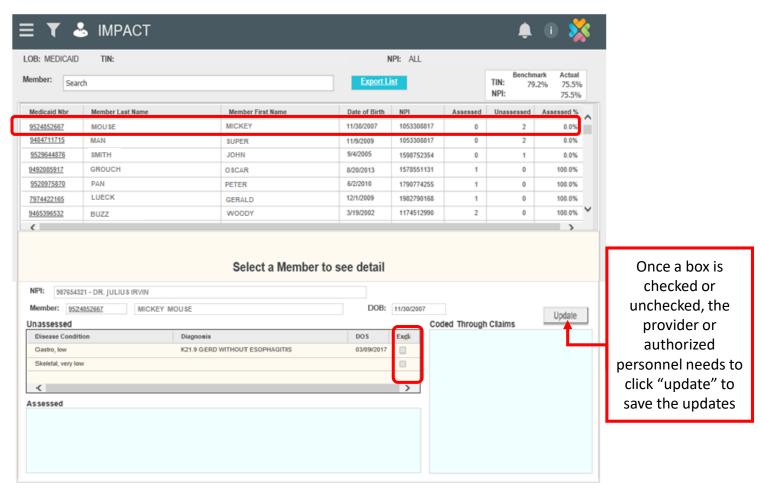
The info button is a drop-down menu containing links to FAQ on program potentially detailed lists of diagnosis codes under each

- The IMPACT dashboard will show providers their benchmark target and their actual performance.
- Providers can search for a specific patient by typing in either the name or Medicaid number of the patient.
- Doctors can view their individual performance and patient list by selecting their name from the filter in the upper left hand corner.
- Users can export their list to Excel.



IMPACT

Providers access gap reports to assess members for suspected conditions



Note: If users export to Excel, they still need to go back into the IMPACT dashboard to enter any exclusions.

* All data shown here is for illustrative purposes only. No actual PHI data is presented.



New Tool— Interpreta

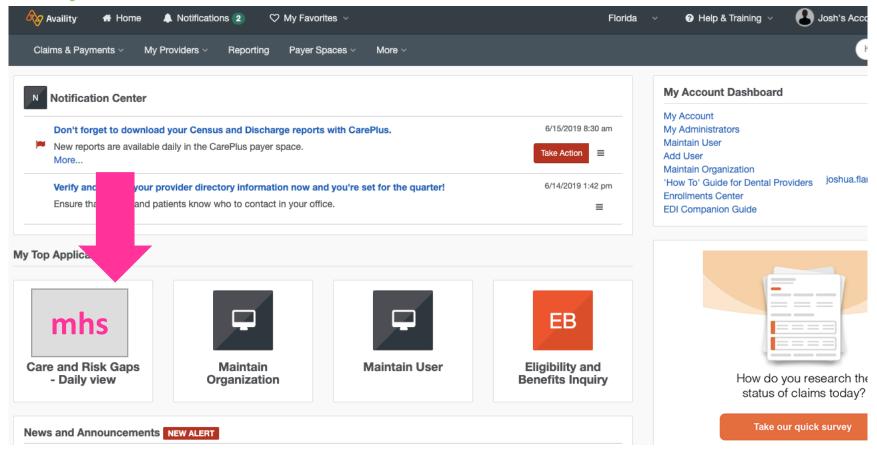
- Maily care gap reports with real-time data
- Providers access Interpreta through the Availity portal
 plans to integrate into Provider Portal in the future
- Continuously updates, interprets, and synchronizes clinical and genomic data
- Creates a personalized member roadmap to orchestrate timely care
- Real-time insights offer patient-specific information needed for quality improvement

Visit Availity's website at Availity.com to create a profile and find easy to use instructions.





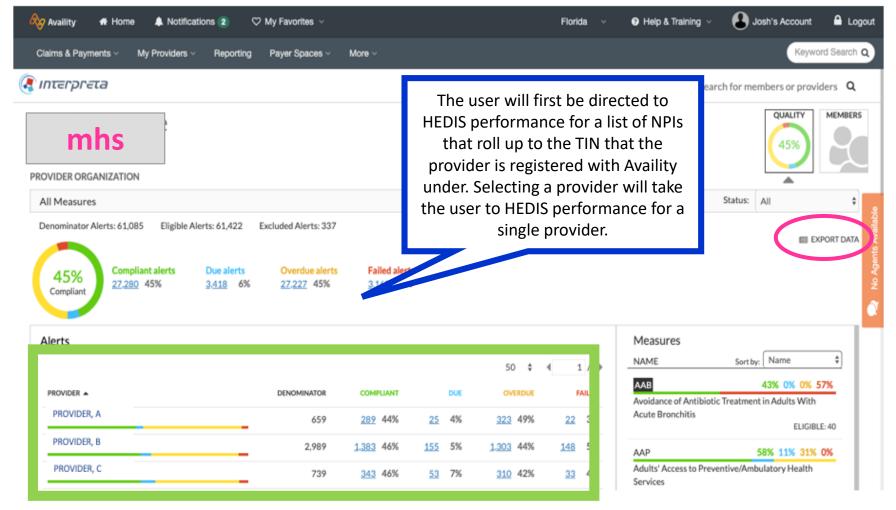
When you log into Availity, the Dashboard is first page you will see.





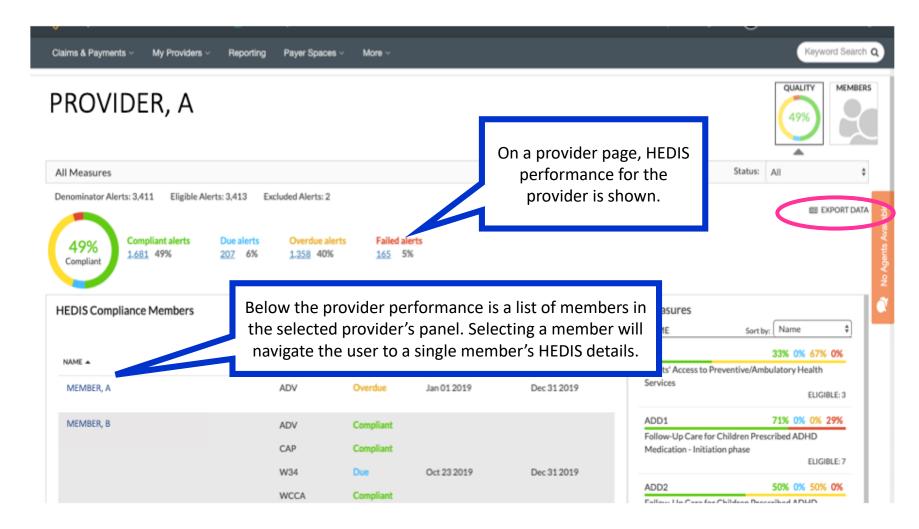
Access the Interpreta care gaps through "My Top Applications".

This will be the first Interpreta page that you see.



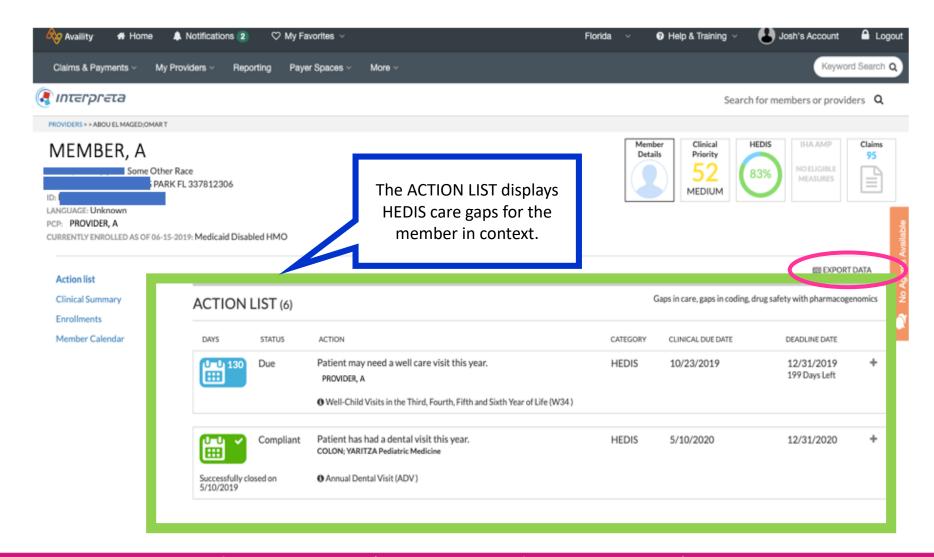






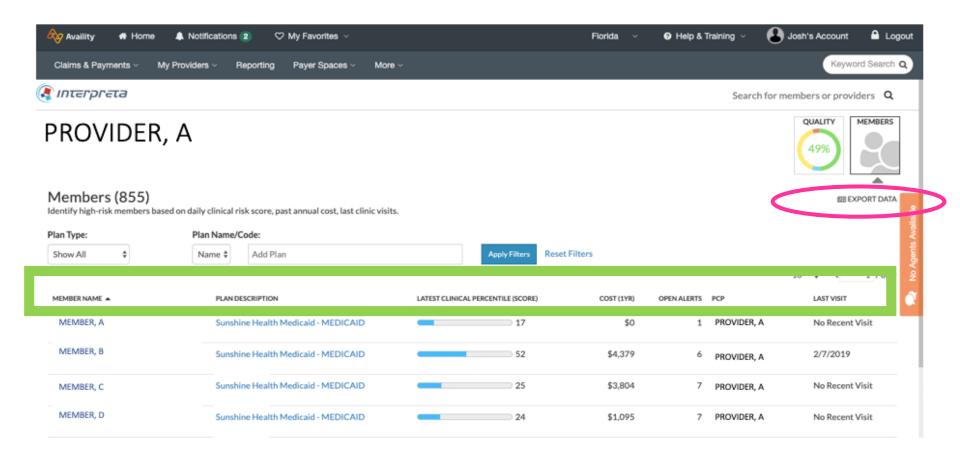








After selecting the MEMBER'S module, the list of members in the provider's panel can be sorted by MEMBER NAME, PLAN DESCRIPTION, LATEST CLINICAL PRIORITY SCORE, COST, OPEN ALERTS, PCP, or LAST VISIT.







myhealth Ødirect

WHAT IS MYHEALTHDIRECT?

MyHealthDirect is a service sponsored by MHS to schedule healthcare appointments for MHS members. You specify the type and quantity of appointments to make available and a MHS team member schedules those appointments with your patients on your behalf.

HOW IT WORKS



MHS contacts and schedules with your patient



Both you and the patient get a confirmation email



You enter the appointment into your PM system



reminder(s) sent to patient



The patient attends their appointment



Once a week you complete a simple attendance report in MyHealthDirect

Key Benefits of the Program:



Free to you & your patients!



More appointments with your hard-to-reach patients



MHS outreaches to patients on your behalf



Better attendance



Improve Quality



Confirmations and reminders



Reduce administrative cost



Option for English or Spanish



Full control over your calendar & appointments



No more 3-way calling!

myhealth Pdirect



Provider Relations Team



MHS Provider Network Territories

NORTHEAST REGION

Claims Issues: MHS_ProviderRelations_NE@mhsindiana.com Chad Pratt, Provider Partnership Associate 1-877-647-4848 ext. 20454 ripratt@mhsindiana.com

CENTRAL REGION

Claims Issues: MHS_ProviderRelations_C@mhsindiana.com Esther Cervantes, Provider Partnership Associate 1-877-647-4848 ext. 20947 Estherling.A.PimentelCervantes@mhsindiana.com

NORTHWEST REGION

Claims Issues: MHS_ProviderRelations_NW@mhsindiana.com Candace Ervin, Provider Partnership Associate 1-877-647-4848 ext. 20187 Candace.V.Ervin@mhsindiana.com

SOUTHWEST REGION

Claims Issues: MHS_ProviderRelations_SW@mhsindiana.com Dawn McCarty, Provider Partnership Associate 1-877-647-4848 ext. 20117

Dawnalee.A.McCarty@mhsindiana.com

SOUTHEAST REGION

Claims Issues: MHS_ProviderRelations_SE@mhsindiana.com 1-877-647-4848

NETWORK LEADERSHIP

Jill Claypool

Vice President, Network Development & Contracting 1-877-647-4848 ext. 20855 jill.e.claypool@mhsindiana.com

Nancy Robinson

Senior Director, Provider Network 1-877-647-4848 ext. 20180 nrobinson@mhsindiana.com

Mark Vonderheit

Director, Provider Network 1-877-647-4848 Ext. 20240 mvonderheit@mhsindiana.com

Indiana



NEW PROVIDER CONTRACTING

Tim Balko

Director, Network Development & Contracting 1-877-647-4848 ext. 20120 tbalko@mhsindiana.com

Michael Funk

Manager, Network Development & Contracting 1-877-647-4848 ext. 20017 michael.j.funk@mhsindiana.com

NETWORK OPERATIONS

Kelvin Orr

Director, Network Operations 1-877-647-4848 ext. 20049 kelvin.d.orr@mhsindiana.com





MHS Provider Network Territories

TAWANNA DANZIE

Provider Partnership Associate II 1-877-647-4848 ext. 20022 tdanzie@mhsindiana.com

PROVIDER GROUPS

Beacon Medical Group

Community Care Network Franciscan Alliance Goshen Health System HealthLinc Heart City Health Center Indiana Health Centers Lutheran Medical Group Northshore Health Centers Parkview Health System South Bend Clinic

JENNIFER GARNER

Provider Partnership Associate II 1-877-647-4848 ext. 20149 jgarner@mhsindiana.com

PROVIDER GROUPS

American Health Network of Indiana Columbus Regional Health Community Physicians of Indiana Good Samaritan Hospital Physician Services HealthNet Health & Hospital Corporation of Marion County Indiana University Health Little Company of Mary Hospital of Indiana Riverview Hospital St. Vincent Medical Group

INTERNAL REPRESENTATIVES

JENNIFER DEAN

Provider Network Specialist 1-877-647-4848 ext. 20221 jedean@mhsindiana.com

LAKISHA BROWDER

Provider Relations Specialist 1-877-647-4848 ext. 20224 lbrowder@mhsindiana.com

ENVOLVE DENTAL, INC.

MICHAEL J. WILLIAMS

Provider Relations Specialist 1-727-437-1832 Dental Provider Services: 1-855-609-5157 Michael.Williams@EnvolveHealth.com



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MHS Provider Relations Team

Tawanna Danzie	Provider Relations Specialist II – Northern Indiana	1-877-647-4848 ext. 20022	tdanzie@mhsindiana.com
Jennifer Garner	Provider Relations Specialist II – Southern Indiana	1-877-647-4848 ext. 20149	_jgarner@mhsindiana.com
Chad Pratt	Provider Relations Specialist – Northeast Region	1-877-647-4848 ext. 20454	ripratt@mhsindiana.com
Candace Ervin	Provider Relat6ions Specialist – Northwest Region	1-877-647-4848 ext. 20187	candace.ervin@mhsindiana.com
Esther Cervantes	Provider Relations Specialist – Central Region	1-877-647-4848 ext. 20947	Estherling.A.PimentelCervant es@mhsindiana.com
Open	Provider Relations Specialist – Southeast Region	1-877-647-4848 ext.	
Dawnalee A. McCarty	Provider Relations Specialist – South West Region	1-877-647-4848 ext. 20117	Dawnalee.a.mccarty@mhsindi ana.com



Questions?

Thank you for being our partner in care.



Session Survey

Please use the QR code or the weblink below to complete a survey about the session you just attended. Each session has a unique survey so be sure to complete the appropriate one for each session you attend. We will be taking your feedback from this survey to improve future IHCP events.



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